Community Health Promotions Council
Executive Session

28 February 2014

LTC Sanderson and Ms. Mootz
U.S Army Garrison, Hawaii

Supporting each Warrior, Family and Community with sustainable services, ensuring power projection readiness from Hawaii

We are the Army's Home

Agenda

Opening Remarks (<5 Min)

Overview (<25 Min)

Break: All (<10 Min)

Work Group Updates: Leads (<10 Min each)

Recap Due Outs: HPRA (<5 Min)

Final Comments (<5 Min)

Ready and Resilient

USARHAW

IMCOM

HQDA

MEDCOM

DA HPRRC

VCSA SSRG

USARPAC Strategic Oversight CHPC

Potential Reporting Areas

- Behavioral Health
- SHARP
- Domestic Violence
- Equal Opportunity
- IDES
- Risk Reduction
- SHARP
- Sponsorship
- STRATCOM
- Strong Bonds
- Substance Abuse
- Suicide Prevention
- Transition

R2 Focus Area Review: Update

CDR's R Updates

CDR's R2 Dashboard

R2TF Synchronized by CoS

Take back Lessons Learned and Best Practices

CHPC Review Board Chair: GC & SCR

CHPC Executive Session Chair: SR CDR

Ready and Resilient Campaign

R2 Focus Area Review: Program Input

CMD Input

Exec CHPC

Fed by trends, updates, and spotlight briefs

R2 Battle Rhythm

Ongoing | R2TF 30 Days | CHPC-B 60 Days | 90 Days

Upcoming Meetings 2Q FY14

R2 Ready and Resilient Task For
(T) 27 MAR 2014, 1330-1500

25ID
Lightning
Strong
OPT

R2 Ready and Resilient Task Fo
(T) 17 APR 2014, 1330-1500

B Community Health Promotion Council Review Board
(T) 25 APR 2014, 1430-1600

E Ready and Resilient Task Force
(T) 22 MAY 2014, 1330-1500

Missions of Mutual Interest

OVERSIGHT

IMCOM

MEDCOM

USARPAC
TRADOC
AMC

AWCs

PHC

CHPCs

Oversight (PH Missions)

DELIVERY

Integrated Delivery of Health Promotion

Army Regulation 600-63 Health Promotion

Army health promotion is defined as any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community.

KEY TASKS

Senior Commander

(1) Establish and chair a Community Health Promotion Council.
(2) Appoint a CHP officer to direct program priorities.
(3) Administer and control the health promotion program through the CHPC and the Health Promotion Officer; these are the commander's primary advisers.

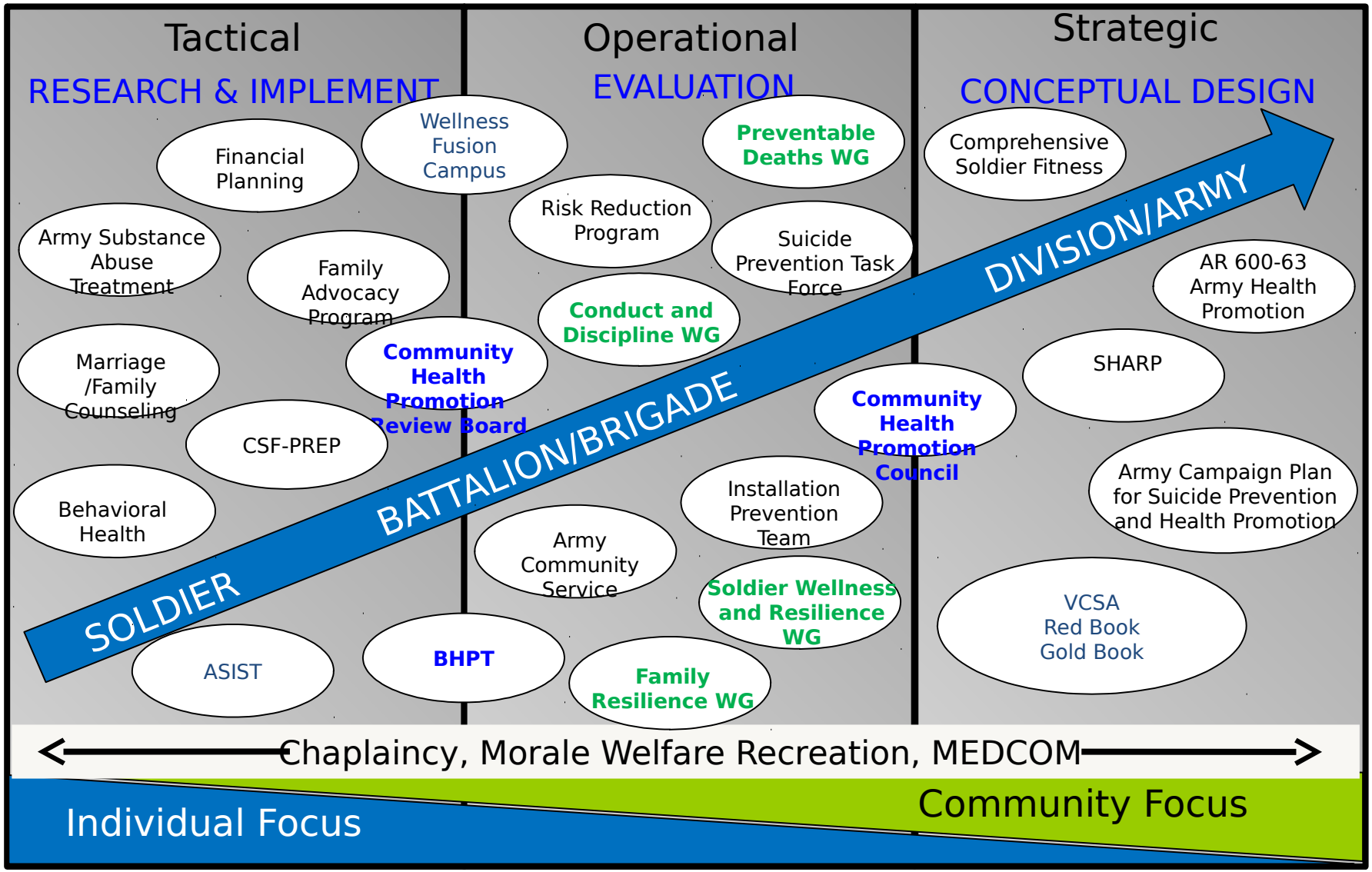
Health Promotion Officer

(1) Serve as liaison between the installation commander, CHPC members and other military and civilian representatives.
(2) Coordinate program priorities.
(3) Advise the commander on the CHPC.
(4) Provide overall administrative assistance to the installation commander and the CHPC.

Community Health Promotion Council

(1) Assess community needs.
(2) Inventory resources.
(3) Analyze data resulting from program assessments and/or evaluations.
(4) Develop, implement, and evaluate courses of action to address identified community needs.
(5) Integrate existing health promotion programs with other similar installation and community programs.
(6) Develop a comprehensive marketing plan based on existing resources and demographics.

CHPC Conceptual Overview



USAG-HI Community Health Promotion Council

Facilitates cooperation, coordination and integration of medical, tactical and garrison assets

Structure

Operational Level

Senior Commander's Community Health Promotion Council (CHPC)
Chaired by: Senior Commander
Facilitated by the Installation Health Promotion Officer
Members include: GO Cdrs/CSMs; Brigade Cdrs/CSMs; Garrison Cdr/CSM; Div Surgeon; Program Director and SMEs

Tactical Level

Senior Medical Leaders Council
Chaired by: Director of Health Services

CHPC Review Board
Chaired by: GC, DCG-S/CoS (SC), Dir HS, HPO
TF Chairs present motions for consideration at CHPC

Soldier Wellness and Resilience Working Group
Chair: SBMC, CDR
AO: Deputy

Conduct and Discipline Working Group
Chair: DES
AO: Deputy

Preventable Death Working Group
Chair: DHR, Director
AO: HPRRSPC

Family Resilience Working Group
Chair: FMWR, Director
AO: ACS, Director

Data Analysis and Integration Task Force
Chair: LTC Sanderson AO: Ms. Mootz

Research Zone: BHPT, CSF(GAT), RRP/URI/R-URI, PHA/PDHRA/PDHA, MEDPROS, APFT, SIR, USR, BH Data, TRICARE (Data Points)

Best Practices facilitated through the CHPC:
- Implement AR 600-63 and VCSA HP/RR/SP Directives
  - Synchronize Health Promotion, Risk Reduction and Suicide Prevention Efforts
  - Coordinate targeted prevention efforts and interventions for health and wellness
  - Facilitate cooperation, collaboration and integration throughout installation health promotion assets
- Integrate medical, mission, and garrison assets
  - Task forces include appropriate SMEs

Emerging Initiatives:
- Brigade Health Promotion Teams (BHPT)
  - BHPT Dashboard
  - Provide structure for CSF MRTs
  - Assists commander with high risk Soldier management
- ACE-SI program
- Provide follow-up with Soldiers' units

Integrated Community Health Promotion

- **National Prevention, Health Promotion, and Public Health Council, PODUS 10 June 2010**
- **HQDA**
- **HP/RR/SP Report**
- **AR 600-63**
- **HPO/APHC**
- **Local Command Groups**
- **Community SMEs**
- **OASD**
- **CDC [illegible]APP**

Drivers

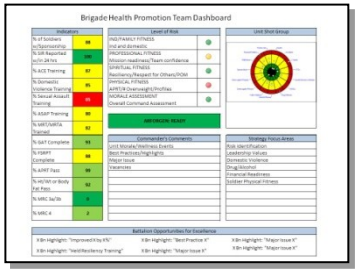
Activities

Evidence of Delivery

Evaluation

Communicate results and measures . Quarterly Impact Tracker and Balanced Scorecard

CHPC Charter
CHPC Chaired by SC
Working Groups and Task Forces
Brigade Health Promotion Teams
Community Assessment Inventory Resources thru CRG
Monitor Trends & Outcomes



Develop Strategic Plan
WG/TF Action Plans
Impact Tracker
CHPC Survey
Structure Process Evaluation Tool
Community Needs Profile
CGR - Web based & hard copy
BHPT Dashboard
Relationship Tracker

Outcomes

NEAR TERM

- Creating an environment that encourages coalition building
- Coordinated approach to systematic data collection
- Awareness of gaps and overlaps
- Change in attitude toward Preventive

SHORT TERM

- Elimination of Silos
- Reduction of gaps and overlaps
- Cost Savings
- Increase and Improve the Health and Wellness of the Community
- Reduction of disease/ illness/injur

LONG TERM

- Integration of Tactical, Medical, & Garrison Assets
- Efficient resource management
- **Fit and Ready Force**

Resilience Program & R2TF Updates

Focus Area:	
Program Information	Program Primary POC (name, email, phone #)
	Program Alternate POC (name, email, phone #)
	Related Meetings (title & frequency/battle rhythm)
	Latest guidance from the Command Group
	Reports/data and outputs (who reported to)
	Program Goals
	Current and Future Initiatives (timeline)
Requirements	Law
	DoD Regulation
	Army Regulation
	USARHAW Regulation
	Other
	Unit requirements (manning, training, etc.)
Measures of Effectiveness	What does a successful program look like in a Unit (how does a Commander know if they are being successful)?
	What metrics should the Commander be tracking in the Unit to get a picture of the Unit?
	What are indicators to a Commander

Ready and Resilient Focus Area	Trends	Measures of Effectiveness	Best Practices	Lessons Learned	Comments
25th ID					
8th TSC					
9th MSC					
311th TSC					
TAMC					
94th AAMDC					
500th MIB					
196th TSB					
18th MEDCOM					
Garrison					
USARPAC					

Assistance Needed

Does your Command have a good news story or vignette related to one of the focus areas to share?

Review of each focus area for decision on agenda topics for the Executive CHPC

Brigade Health Promotion Team (BHPT)

Meeting

Brigade Health Promotion Team (BHPT) Model

Inputs

Membership:

BDE Cdr/DCO
BDE MRT
BDE Surgeon
BDE Embedded BH
BDE SJA
BDE Nurse
BDE ESO
BDE Physical Therapist
BDE Chaplain
BDE Provost Marshal
BDE IO
BDE Sexual Assault Response
BDE EO
BDE ADCO/ASAP
BDE Safety Officer
BDE FRSA
BDE MFLC
BDE BOSS Rep

Data Source Examples: Sick call, PHA, PDHRA, Blotter Report, Unit UA report, Risk Reduction Data, MEDPROS, Safety Officer Report, Chaplain 370R

Activities

Monthly meetings: review trends and ongoing

Monitoring trends and outcomes of DA mandated and unit driven trainings.

Identify and prioritize BDE risk factors to mitigate negative trends.

Utilize and integrate community resources and coordination of care process for at risk Soldiers.

(e.g., missed appts, referrals, progress, care and services issues)

Make recommendations to training calendar for unit targeted risk reduction training

Recommend COA strategies for at risk units/Soldiers.

Report Dashboards at CHPC to share lessons learned.

Outputs

BHPT Meeting minutes
Monthly dashboard
CHPC Participation

Outcomes

NEAR TERM

- Enhanced command teams pulse on the status of health and behavioral issues
- Increased Leader awareness and responsiveness
- Enhanced command teams monitoring

SHORT TERM

- Rapid unit policy changes tailored to meet the needs of unit
- Increased command team responsive to unit issues.
- Evidence based decision making

LONG TERM

- Integration of Tactical, Medical, & Garrison Assets
- Efficient resource management
- **Fit and Ready Force**

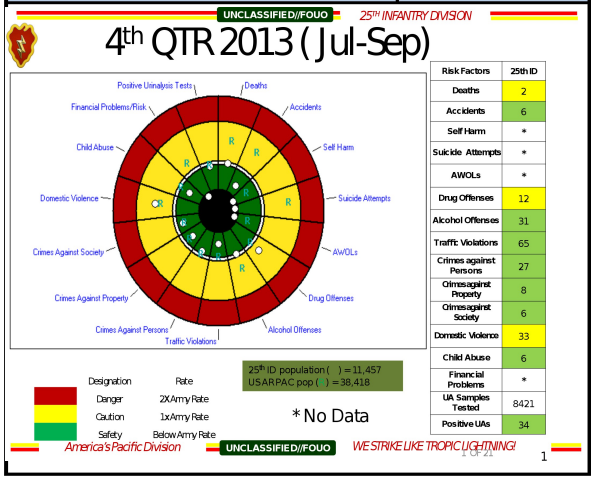
Brigade Health Promotion Team Dashboard

Indicators	
%of Soldiers w/Sponsorship	88
%SIR Reported w/in 24 hrs	100
%ACE Training	87
%Domestic Violence Training	85
%Sexual Assault Training	65
%ASAP Training	80
%MRT/MRTA Trained	82
%GAT Complete	93
%FSRPT Complete	88
%APRT Pass	99
%Ht/Wt or Body Fat Pass	92
%MRC 3a/3b	0
%MRC 4	2

Level of Risk	
IND/FAMILY FITNESS Ind and domestic	
PROFESSIONAL FITNESS Mission readiness/Team confidence	
SPIRITUAL FITNESS Resiliency/Respect for Others/POM	
PHYSICAL FITNESS APRT/#Overweight/Profiles	
MORALE ASSESSMENT Overall Command Assessment	

ARFORGEN: READY

Unit Shot Group



Commander's Comments
Unit Morale/Wellness Events
Best Practices/Highlights
Major Issue
Vacancies

Strategy Focus Areas
Risk Identification
Leadership Values
Domestic Violence
Drug/Alcohol
Financial Readiness
Soldier Physical Fitness

Battalion Opportunities for Excellence

XBn Highlight: "Improved X by X%"	XBn Highlight: "Best Practice X"	XBn Highlight: "Major Issue X"
XBn Highlight: "Held Resiliency Training"	XBn Highlight: "Major Issue X"	XBn Highlight: "Major Issue X"

Health Promotion Teams (HPTs) Meeting

Battalion Health Promotion Team Dashboard

Unit : XX BN

	TRENDS:	ACTION PLAN / STATUS:
Assigned: **Completed MRT:** **MRTs Assigned:**		
Low:		
Moderate:	**TRENDS:**	**RESOURCE REQUIREMENTS:**
High:		

Battalion Health Promotion Team Dashboard
Unit: XX BN

As of DTG

Assigned:

MEDPROS: %

MRT trained :%

PPPT(EL/Part): # / #

High:

SEP	OCT	NOV
#	#	#

Moderate:

SEP	OCT	NOV
#	#	#

Low:

SEP	OCT	NOV
#	#	#

TREND	OCT	NOV	DEC
TRENDS: Positive			
College Enrollment	#	#	#
Volunteer Hours	#	#	#
APRT >270	#	#	#
UMT Assigned/Required	# / #	# / #	# / #
MRT Assigned/Required	# / #	# / #	# / #
UVA Assigned/Required	# / #	# / #	# / #
TRENDS: Disciplinary			
Crimes People/ Property	#	#	#
UCMJ Repeat Offenders	#	#	#
Curfew Violations	#	#	#
Alcohol Incidents	#	#	#
Drug Incidents	#	#	#
Assault Offenses	#	#	#
TRENDS: Social/Behavioral			
Counseling Suicides/Attempts	#	#	#
Depression Intervention w/ UMT	#	#	#
ASAP Enrollment	#	#	#
Marital/Relationship Issues	#	#	#
Family Dynamics/Separation	#	#	#
Job-Related Stress	#	#	#
TRENDS: Others			
CSP/AIP Issues	#	#	#
Overweight	#	#	#
APFT Failure	#	#	#
SH/SA Victims	#	#	#

Unit Level Prevention/Action Plan

How do we know we are being effective?

Resource Requirements:

Health Promotion Team Monthly Meeting

CDR/1SG
Oversight
Agenda
Hold Monthly Meetings
Legal Counsel
Claims
Adverse Actions

Company
Contact Weekly
Facilitate meetings

MEDO
Injuries
Treatment Facility
Contact Information
Medication Tracking

PLT
Soldier progress, counseling packet
Daily Checks

HQ's
Report attended and missed meetings
Update BBC
Update Book
NOK Contact Info

CHP
Counsel
Spiritual Fitness
Moral Feedback
Family Feedback

PA
Track emotional status
Report trends
Periodic follow-up
Coordinate w/ Behavior Health
Profiles (Trends)
High risk Meetings

SENIOR C

X Co WELLNESS CLIMATE ASSESSMENT

OIP ASSESEMENTS (G= "T"; A="P"; R="U")		UNIT RISK INVENTORYs/ ARAP / COMMAND ASSESSMENT	
SPONSORSHIP		ACCIDENTS / SAFETY VIOLATIONS	
FRG		TRAFFIC VIOLATIONS	
BOSS		PROFILES / OVERWEIGHT	
PROMOTIONS		CRIMES AGAINST PROPERTY	
AWARDS		LEADERSHIP SHORTFALLS	
PT / 4 MILE RUN		STDs	
RETENTION		DRUG ABUSE / POSITIVE UAs	
LDR DEV PROGRAMS		ALCOHOL ABUSE	
COUNSELING		SPOUSE / CHILD ABUSE	
EO/POSH/CO2		SUICIDE / IDEATIONS / MENTAL HEALTH	

COMMAND DASHBOARD RISK ASSESSMENT

HIGH / MED / LOW

INDIVIDUAL/FAMILY

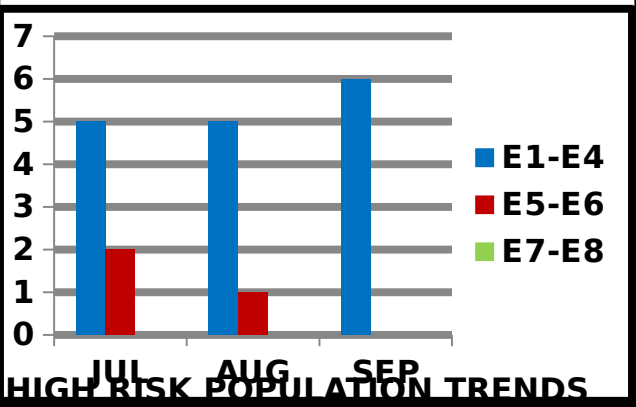
PROFESSIONAL

SPIRITUAL

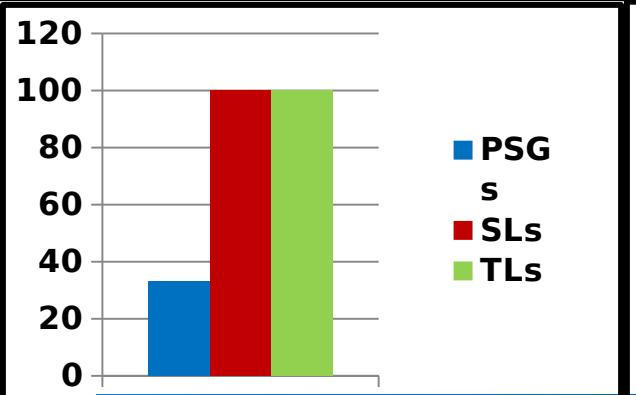
PHYSICAL

MORALE

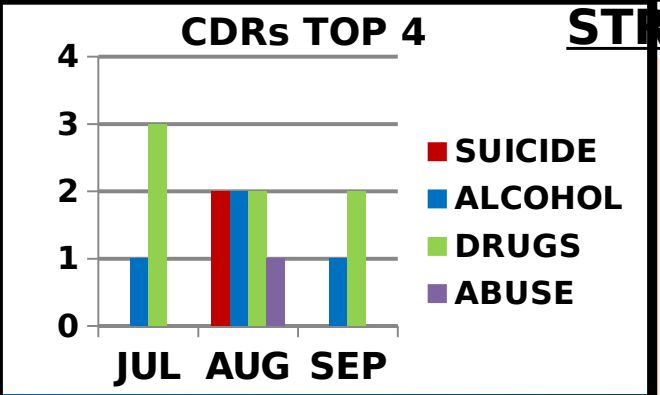
HIGH RISK POPULATION 6



HIGH RISK POPULATION TRENDS



LDRSHP MANNING



STRATEGY FOCUS AREAS

SOLDIER & FAMILY FITNESS

- Drug Abuse (350-1, MRT, CATEP, ASAP, H&W Inspections)
- Domestic Violence (Chaplain Counseling, 350-1)
- Depression / Suicide (Weekly checks, care team meetings monthly)
- Family Care (FRG meetings)

SPC Joe Snuffy

Soldier Picture

Risk Level	High
Recommend Retain:	Yes
Date of Chapter initiation:	N/A

Soldier Data

Name:

DOB: FEB 18 1984

Battle Buddy:

Current Location:

NOK:

Years in Service: 3 YR 0 MO

# of Deployments:

Address:

Date/Incidents/Commanders Report of Disciplinary Action (DA Form 4833) Status

29 Aug 10	Contacted his team leader via text message and indicated that on the night prior he had attempted to overdose with his prescription for Xanax and alcohol. The PL was notified, and directed the SL to pick SPC Faivre up from the barracks and take him to the ER at EACH. SPC Faivre was admitted transferred to St. Francis Medical Center
1 Sep 10	Discharged from St. Francis
1 Sep 10	Screened/enrolled in ASAP

Plan of Action to Improve SDR Wellness

Case Manager	APT Schedule	Medications

Summary of LDR Engagement

Date	Control Person	Comments
2 Sep		Counseled soldier prior to long weekend; admitted a moment of weakness and regret for his actions. Seems positive about the future.
9 Sep		continues to show progress, seems to be back to his normal behavior.
19 Oct		Talked to him after the field problem; getting back into training has improved his morale.

Questions

Agenda

Opening Remarks (<5 Min)

Previous Due Outs: HPO (<10 Min)

Work Group Updates: Leads (<10 Min x 4 each)

Break: All (<10 Min)

Unit Trends: MSC Reps (<15 Min x 3 each)

Recap Due Outs: HPRA (<5 Min)

Final Comments (<5 Min)

Opening Remarks

***PURPOSE**: The Council serves as a unified mechanism for sharing information between commanders and working groups for the purpose of*

developing recommendations and strategies to promote healthy lifestyles , increase Soldier and Family resiliency, mitigate high risk behavior, and support overall mission readiness.

Community Health Promotion Council

Proposed Way Ahead

Strategic Level

Community Health Promotion Council Meeting – Executive Session
Chair: Senior Commander **(SC)**
(Quarterly – 90 Days)

Operational Level

Community Health Promotion Council Review Board
Chair: GC & SCR
(Quarterly – 60 Days)

(Part I)
(50%)
Work Group Updates
Chair: GC & SCR
Agency & Organization Representatives involved in Social, Family, Spiritual, Behavioral, Financial & Physical Wellbeing of the Community

(Part II)
(50%)
Unit Health Promotion Team Updates
Chair: GC &SCR
BDE CDRs & Identified Service Agency Representatives

Tactical Level

Brigade Health Promotion Teams (BHPTs)
Chair: BDE CDR
(Monthly – 30 Days)

HPTs
Chair: BN/ CO CDRs
(Monthly – 30 Days)

Community Health Promotion Council

MSC Way Ahead

Strategic Level

Lightning Strong OPT
Chair: DCG-S
(Quarterly)

Operational Level

Brigade Health Promotion Team
Chair: Brigade Commander
(Monthly)

(Part I)	(Part II)
Force Health Protection Committee **Chair: BDE HBO** **BN CDRs & Organization SMEs involved in Social, Family, Spiritual, Behavioral, Financial & Physical Wellbeing of the Organization**	**At Risk Soldier Identification & Coordination** **Chair: BDE HBO** **BN CDRs & BDE Health Promotion Team**

Tactical Level

BN (CO) Steering Committees Organic SMEs (MRTs, SRTs, etc)	(CO) Family Readiness Group (PLT) RV3, Monthly Counseling, SMEs

DUE-OUTs

CHPC Dash Board: Ready and Resilient

Focus Area:	
Program Information	Program Primary POC (name, email, phone #)
	Program Alternate POC (name, email, phone #)
	Related Meetings (title & frequency/battle rhythm)
	Latest guidance from the Command Group
	Reports/data and outputs (who reported to)
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Ready and Resilient Focus Area	Trends	Measures of Effectiveness	Best Practices	Lessons Learned	Comments
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8th TSC					
9th MSC					
311th TSC					
TAMC					
94th AAMDC					
500th MIB					
196th TSB					
18th MEDCOM					
Garrison					
USARPAC					

Assistance Needed

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Review of each focus area for decision on agenda topics for the Executive CHPC

Working Group Updates

Soldier Wellness and Resilience Working Group

Conduct and Discipline Working Group

Preventable Death Working Group

Family Resilience Working Group

Soldier Wellness and Resilience Working Group

- Definitions:
  - Wellness is the state or condition of being in good physical and mental health.
  - Resilience is the ability to bounce back from adversity; the capacity to recover quickly from difficulties; toughness
- Proposed WG membership: Select 25th ID staff (chaplain, psychiatrist, surgeon, Lightning Strong Lead), select 8th TSC staff (surgeon, chaplain), Army PH Nursing, PH Command, CSF2, garrison CH, MWR, Psych Health Director
- Review and synchronize wellness and resilience programs to maximize efficacy and minimize duplication. Track effect on Soldier readiness and family member wellness measures

Soldier Wellness and Resilience Working Group

1) WORKING ISSUES/TRENDS:

Policy: OPRORD 12-17
Program: Army Wellness Center
Training: NA
Resource: Designated space
Gap: Designated building, MOU, PH funding

2) DESIRED OUTCOME:

Dedicated Army Wellness Center to support wellness and resilience for USARHAW Soldiers and Families

3) : ACTION PLAN:

-Procure dedicated space
-Gain concurrence for MOU
-Submit requirements to PHC for central funding

4) CHALLENGES/STATUS:

-Commitment of appropriate space

Task Force, Program & Cell

Senior Medical Council (As of 24 FEB 14)

POSITIVE TRENDS:

- Improved Soldier readiness
- Recognition of Schofield Soldier BH requirements
- Decreased Acute Care visits

NEGATIVE TRENDS:

- Decreased staffing for family member BH

ACTION PLANS / STATUS:

- Intensive Outpatient Program
Program for Soldier BH
-Revision of SRP operations to post-OCO funding requirements
- Expansion of medical homes

RESOURCE REQUIREMENTS:

Conduct and Discipline Working Group

- Definitions:
  -
- Proposed WG membership:
  -

Conduct and Discipline Working Group

1) WORKING ISSUES/TRENDS:

Policy:
Program:
Training:
Resource:
Gap:

2) DESIRED OUTCOME:

-

3) : ACTION PLAN:

-

4) CHALLENGES/STATUS:

-

Task Force, Program & Committee

Courtesy Patrol (As of DTG)

POSITIVE TRENDS:

-

ACTION PLANS / STATUS:

-

-

NEGATIVE TRENDS:

-

RESOURCE REQUIREMENTS:

-

-

Preventable Death Working Group

- Definition of Preventable Death: A death that, had certain specific measures been taken, could possibly have been prevented.
- Proposed membership: Family Advocacy Program (FAP) Prevention and Treatment, Fatality Review Board (FRB), Adolescent Substance Abuse Counseling Services (ASACS), DES, CID, Master Resiliency Trainers, MEDCOM, Behavioral Health, ASAP, Risk Reduction, Suicide Prevention, Fusion Cell, SJA, 25ID G1, 8TSC G1, Safety, Chaplain, EEO, SHARP, and IG
- Review data on deaths in FY 13 to determine data points, look for lessons, identify trends, root cause Analysis

Preventable Death Working Group

1) WORKING ISSUES/TRENDS:

Policy: Revise to merge meetings
Program: Communication/data
Training: TBD
Resource: Efficient consolidation
Gap: Current methods of practice

2) DESIRED OUTCOME:

- Define the problem
- Save lives
- DA Safety Data

3) : ACTION PLAN:

- Definition
- Players
- Review current data to establish parameters, identify leading/lagging measures
- Determine course

4) CHALLENGES/STATUS:

- Lags in data: i.e., FRB investigations of domestic violence (DV) related deaths is two years after the event
- Data not available/communicated
- Consider combining efforts

Task Force, Program & Teams

Suicide Prevention Task Force

POSITIVE TRENDS:

- SIRs on ideations indicate positive actions of units/soldiers
- October MTT (Mobile Training Team Train the Trainer) certified 149 ACE-SI and 44 ASIST instructors
- Monthly ASIST and ACE-SI offered

NEGATIVE TRENDS:

- Increased restrictions of sensitive information makes it difficult to analyze trends from SIRs/blotter
- Units lack compliance with mandatory ACE-SI training and DTMS documentation

ACTION PLANS / STATUS:

- Align SP Task Force with new CHPC Preventable Death working group
- Leadership Paradigm
- Develop campaign materials/publicity
- Request DPTMS reports in order to monitor all SP training across USARHAW

RESOURCE REQUIREMENTS:

- Pending further study

Task Force, Program & Teams

Installation Prevention Team (IPT)

TFs,

POSITIVE TRENDS:

- Command emphasis on prevention
- Decreased deployment = increased training
- Increased focus on incoming troops

NEGATIVE TRENDS:

- Inconsistent SIR/blotter access
- Incomplete/inaccurate data
- New drug trends/laws in continental U.S. (Colorado, etc.)

ACTION PLANS / STATUS:

- Align IPT with new CHPC Preventable Deaths working group
- Leadership Paradigm
- Detail action plans for best practices among units
- Review data for accuracy and establish monitoring procedures

RESOURCE REQUIREMENTS:

- Pending further study

Family Resilience Working Group

- Definition of Family Resilience: A family acting in whole that exercises and exhibits traits that lead to successful adaptation and coping to a significant stressor or adversity. As one of the 5 dimensions of strength, family is defined as:
  - Family = Being part of a family unit that is safe, supportive and loving, and provides the resources needed for all members to live in a healthy and secure environment
  - A resilient family is one that retains the above qualities even in the face of adversity.

- Proposed WG Primary Membership:
  - Family and MWR (ACS(FAP, SOS,EFMP,SFAC) CYSS, Recreation, Business, Support)
  - Chaplains
  - MEDCOM
  - DHR
  - Housing and IPC
  - CSF2 office
  - 25ID G1, 8TSC G1

Family Resilience Working Group

1) WORKING ISSUES/TRENDS:

- Policy: AR608, AR215, TBD
- Program(s): CSF2, R2C, Strong Bonds
- Training: MRT, TBD
- Resource: TBD
- Gap: TBD

2) DESIRED OUTCOME:

- Displayed skills of resiliency for families to successfully adapt to the demand and changes of today's modern Army.

"Resilient Families"

3) : ACTION PLAN:

- Players- Identify Agency POC
- Review current data to establish baselines, parameters, identify leading/lagging measures
- Determine course of WG and Task Force(s)

4) CHALLENGES/STATUS:

- Fiscal Environment (Funding and Staff)
- Cultural change
- Managing Expectations
- Sense of Entitlement

Task Force, Program & Teams

Family Resilience Program (As of DTG)

POSITIVE TRENDS:

-FAP Outreach and Utilization reached 70K
-Youth Sports Participation (700-800 per sport)
-Higher than Army average on-post housing
-AER Command Referral Program 20% = higher Army Average

NEGATIVE TRENDS:

-Domestic Violence and Child Abuse cases are higher in USARHAW then Army average
DV= 10.1 vice 6.3 per 1000
CA= 9.6 vice 6.3 per 1000
-CYSS Waitlist for Children
-CYSS Staff Recruitments/Vacancies (5 Rooms Closed)

ACTION PLANS / STATUS:

-Identify Measurement of Performance

-Identify Measurements of Effectiveness

-Continue to focus on positive trends

-Establish plans to reduce negative trends

RESOURCE REQUIREMENTS:

-TBD

-Continue working with CPAC to Hire Qualified/Cleared CYSS Staff

Community Health Promotion Council

This concludes Part I

Work Group Update

10 Minute Break

Part II:

R2TF Updates

Quarterly Summary

Moderate-High Risk Soldier Trend

	*Assigned	Moderate	High
Oct	3801	118 (3.1%)	**55 (1.4%)**
Nov	4037	140 (3.5%)	**65 (1.6%)**
Dec	4110	170 (4.1%)	**61 (1.48%)**

*Assigned designates those units who reported to the CHPC-C each month

MSC Unit Trends

25th ID
8th TSC
9th MSC
311th TSC
TAMC
94th AAMDC
500th MIB
196th TSB
18th MEDCOM

MSC Health Promotion Team Dashboard

Indicators	
%of Soldiers w/Sponsorship	88
%SIR Reported w/in 24 hrs	100
%ACE Training	87
%Domestic Violence Training	85
%Sexual Assault Training	65
%ASAP Training	80
%MRT/MRTA Trained	82
%GAT Complete	93
%FSRPT Complete	88
%APRT Pass	99
%Ht/Wt or Body Fat Pass	92
%MRC 3a/3b	0
%MRC 4	2

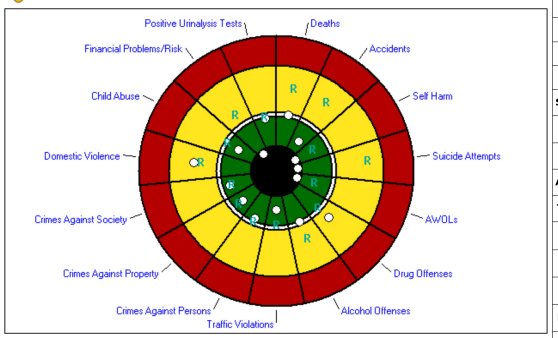
Level of Risk
IND/FAMILY FITNESS Ind and domestic
PROFESSIONAL FITNESS Mission readiness/Team confidence
SPIRITUAL FITNESS Resiliency/Respect for Others/POM
PHYSICAL FITNESS APRT/#Overweight/Profiles
MORALE ASSESSMENT Overall Command Assessment

ARFORGEN: READY

UNCLASSIFIED//FOUO

25TH INFANTRY DIVISION

4th QTR 2013 (Jul-Sep)



Risk Factors	25th ID
Deaths	2
Accidents	6
Self Harm	*
Suicide Attempts	*
AWOLs	*
Drug Offenses	12
Alcohol Offenses	31
Traffic Violations	65
Crimes against Persons	27
Crimes against Property	8
Crimes against Society	6
Domestic Violence	33
Child Abuse	6
Financial Problems	*
UA Samples Tested	8421
Positive UAs	34

Designation	Rate
Danger	2X Army Rate
Caution	1x Army Rate
Safety	Below Army Rate

25th ID population ( ) = 11,457
USARPAC pop ( ) = 38,418

*No Data

America's Pacific Division

UNCLASSIFIED//FOUO

WE STRIKE LIKE TROPIC LIGHTNING!

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Commander's Comments
Unit Morale/Wellness Events
Best Practices/Highlights
Major Issue
Vacancies

Strategy Focus Areas
Risk Identification
Leadership Values
Domestic Violence
Drug/Alcohol
Financial Readiness
Soldier Physical Fitness

Battalion Opportunities for Excellence		
XBn Highlight: "Improved X by X%"	XBn Highlight: "Best Practice X"	XBn Highlight: "Major Issue X"
XBn Highlight: "Held Resiliency Training"	XBn Highlight: "Major Issue X"	XBn Highlight: "Major Issue X"

DUE-OUTs

- ❑ All Council members read and be familiar with RR Campaign
- ❑ Dashboard assessments at brigade and battalion level and BPT present at next council meeting
- ❑ BDE commaders identify potential gaps in BHPT membership and work with individual agencies to fill those gaps
- ❑ BDE commanders give consideration to how assessments are being done at company/individual level (Ready V3, etc)
- ❑ Establish good conduct and discipline working group with senior NCO participation
- ❑ Family resilience working group prioritize programs
- ❑ MSC dashboards will be presented at next council meeting
- ❑ Working groups will select and brief relevant performance measures at next council meeting

Meeting Schedule

Next scheduled meeting is
Friday, 30 May 2014
Time: 0930-1130

Location: Post Conference Room

Questions